STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00107010. Complaint IN00107010 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey Dates: April 23, 24, 25, 26, and 27, 2012 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 Survey Team: Heather Lay, RN - TC Janet Stanton, RN Michelle Hosteter, RN Melanie Strycker, RN Census Bed Type: SNF: 23 SNF/NF: 97 Total: 120 Census Payor Type: Medicare: 23 Medicaid: 66 Other: 31 Total: 120	F0000	This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey review on or after 5/27/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 24 Supplemental sample: 1 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/02/12 by Suzanne Williams, RN			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report an allegation of	F0225	F0225 1. What corrective actions will be accomplished for those residents found to have	05/27/2012

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	verbal abuse to the State agencies, and during an abuse investigation the alleged violator was not immediately suspended from work or reassigned. The deficient practice impacted 1 of 2 residents reviewed for alleged abuse violations from a survey sample of 24 residents reviewed. [Resident #115] Findings include: During entrance conference on 4-23-12 at 10:15 A.M., the facility's abuse prohibition policy and procedure and 2-3 written reports of alleged abuse violations were requested from the Executive Director for completion of the "Abuse Prohibition Protocol." On 4-23-12 at 10:30 A.M., the Executive Director provided the facility's "Abuse Prohibition, Reporting, and Investigation Policy and Procedure," dated February 2010. At that time, the abuse policy and procedure was reviewed and included, but was not limited to, a definition of verbal abuse as follows: "Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance... Examples would include, but are not limited to: threats of harm, saying things to frighten a resident		been affected by deficient practice? The CNA was terminated on 3/6/12. All staff have been educated on 5/8/12 regarding Abuse, and abuse reporting. Social Service will follow up with #115 for any psycosocial needs she may have. She will also call the family weekly for 4 weeks to ensure any concerns will be prombtly identified and resolved. 2.How other residents having the potential to be affected by same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. A mandatory inservice held on 5/8/12 regarding Abuse and Abuse reporting was held . All potential allegations of Abuse will be reported timely to the Director of Nursing and the executive Director for investigation and reporting per policy. Any employee that is alledged will be suspended immediately pending outcome of investigation. 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur? Any alledged Abuse will be investigated immediately per Abuse protocol by the ED/ or Designee and reported to ISDH and other entities per policy. a mandatory inservice was held on 5/8/12 on Abuse, Abuse reporting and allegations of abuse. All allegations of Abuse will be	

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	... or scolding and/or speaking to them in harsh voice tones." On 4-24-12 at 9:00 A.M., the Executive Director provided the facility's abuse investigation for Resident #115. At that time, a "Resident Event Investigation Questionnaire" and an "Employee Communication Form" were reviewed. The "Resident Event Investigation Questionnaire" included, but was not limited to, "Resident Name: [Resident #115]... Nature of Event: 'Res Abuse' [with a line drawn through both words, and written next were the words] 'Staff attitude' ... Date of Event: 3-2-12... Summary of Investigation: CNA said to assigned resident, 'You keep asking me the same thing. I told you I will do it when I get done; I'm busy.' CNA was just hired. This attitude is not tolerated by management." The written narrative of the investigation from the Executive Director included, but was not limited to, the following information: On 3-2-12, at 12:00 P.M., ED/DNS [Executive Director/Director of Nursing Services] notified of the incident. On 3-2-12, at 3:00 P.M., MD [Medical		reported timely to the Director of Nursing and to the Executive Director for investigation and reporting to ISDH and other entities. The alledged involved will be immediately suspended pending the outcome of the investigation. ED will ensure all abuse allegations will be reported to ISDH per ASC policy. All allegations of abuse/employee misconduct will be reviewed with the Director of Operations to ensure abuse policy is followed including reporting to ISDH. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur? To ensure compliance the DNS/ or designee is responsible for completion of the Abuse CQI tool, weekly for 4 weeks, bi-monthly for 2 months and quartley until compliance is maintained for 2 consecutive quarters. the results of these Audits will be reviewed by the CQI committee overseen by the ED. if threshold of 100% is not achieved an action plan will be devloped to assure compliance. Completion date 5/27/12	

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	Doctor] was notified of the incident. On 3-2-12, at 3:00 P.M., Family was notified of the incident. Written next to "ISDH notified date" was "N/A [Not applicable]." Written next to "APS notified date" was "N/A." Written next to "Ombudsmen notified date" was "N/A." A written statement by LPN #13 with no date or time noted indicated, "CNA [#14] walking out of dining room and said to one resident 'You keep asking me the same thing, I told you I'll do it when I get done, I'm busy.' CNA left dining room, came back and said to a resident, 'I wish I could just leave you in here.' I then called CNA to hallway, explaining to her this was an inappropriate way to speak to a resident. She said, 'OK, thanks' and walked away." A written statement by LPN #3 with no date or time noted indicated, "On 3-2-12, during lunch. CNA walked into assist dining room and told a res [resident] 'she wished she could just leave her in here.' Charge nurse immediately spoke to CNA about her comment/behavior."			

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A written statement by DNS dated 3-6-12 and titled "Summary of the Alleged Abuse Investigation" indicated "DNS and Social Service Director concluded the investigation. It was discovered that CNA was not being respectful to the resident. It is against our policy as ASC to condone any form of disrespectful act by any of our staff to our residents. Subsequently CNA was terminated by DNS on 3-6-12."

On 4-24-12 at 12:00 P.M., Resident D's record was reviewed. Diagnoses included, but were not limited to, dementia. An MDS [Minimum Data Set] assessment screening dated 4-6-12, included, but was not limited to, "BIMS [Brief Interview Mental Status] screening score 8 [moderate cognitive impairment] ... Behavioral Symptom - Presence and Frequency: Delirium present ...."

A "Nurses Notes" dated 3-2-12, at 3:00 P.M., included, but was not limited to, "Call placed to [name of daughter] re [regarding] staff making inappropriate comments to resident; spoke with resident who had no concerns at this time. Follow up with psyco[sic]-social needs per social services. MD notified, no new orders."

On 4-25-12, the DNS provided the

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	facility's time sheet, dated 3-1-12 through 3-30-12. CNA #14 was present on 3-2-12 [date of alleged abuse allegation] from 6:42 A.M. to 3:08 P.M. In an interview on 4-27-12, at 1:10 P.M., the Executive Director indicated how he always handled investigations was to ask the resident first, then decide whether to report to State agencies. He indicated, otherwise, he'd be reporting every day. In an interview on 4-27-12, at 2:20 P.M., the Executive Director indicated this was not abuse; it was "staff attitude." The Director of Nursing indicated the employee was terminated. 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting alleged abuse to the State agencies, and the facility failed to follow their policy related to protection of residents during an alleged abuse investigation as the alleged violator was not immediately suspended from work or reassigned during the investigation. The deficient practice impacted 1 of 2 residents reviewed for alleged abuse violations from a survey sample of 24 residents reviewed. [Resident #115] Findings include: During entrance conference on 4-23-12 at 10:15 A.M., the facility's abuse prohibition policy and procedure and 2-3 written reports of alleged abuse violations were requested from the Executive Director for completion of the "Abuse Prohibition Protocol." On 4-23-12 at 10:30 A.M., the Executive Director provided the facility's "Abuse	F0226	1. What corrective actions will be accomplished for those residents found to have been affected by deficient practice? The CNA was terminated on 3/6/12. All staff have been educated on 5/8/12 regarding Abuse, and abuse reporting. Social Service will follow up with #115 for any psycosocial needs she may have. She will also call the family weekly for 4 weeks to ensure any concerns will be prombtly identified and resolved.2.How other residents having the potential to be affected by same deficient practice will be identified and what corrective actions will be taken?All residents have the potential to be affected. A mandatory inservice held on 5/8/12 regarding Abuse and Abuse reporting was held . All potential allegations of Abuse will be reported timely to the Director of Nursing and the executive Director for investigation and reporting per policy. Any employee that is alledged will be suspended immediately pending outcome of investigation.3. What measures will be put in place or what systematic changes will be made to ensure that the deficient	05/27/2012

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	Prohibition, Reporting, and Investigation Policy and Procedure," dated February 2010. At that time, the abuse policy and procedure was reviewed and included, but was not limited to, a definition of verbal abuse as follows: "Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance... Examples would include, but are not limited to: threats of harm, saying things to frighten a resident ... or scolding and/or speaking to them in harsh voice tones." On 4-24-12 at 9:00 A.M., the Executive Director provided the facility's abuse investigation for Resident #115. At that time, a "Resident Event Investigation Questionnaire" and an "Employee Communication Form" were reviewed. The "Resident Event Investigation Questionnaire" included, but was not limited to, "Resident Name: [Resident #115]... Nature of Event: 'Res Abuse' [with a line drawn through both words, and written next were the words] 'Staff attitude' ... Date of Event: 3-2-12... Summary of Investigation: CNA said to assigned resident, 'You keep asking me the same thing. I told you I will do it when I get done; I'm busy.' CNA was just		practice does not recur?Any alledged Abuse will be investigated immediately per Abuse protocol by the ED/ or Designee. a mandatory inservice was held on 5/8/12 on Abuse, Abuse reporting and allegations of abuse. All allegations of Abuse will be reported timely to the Director of Nursing and to the Executive Director for investigation and reporting to ISDH and other entities. The alledged involved will be immediately suspended pending the outcome of the investigation.4.How the corrective actions will be monitored to ensure the deficient practice will not recur?To ensure compliance the DNS/ or designee is responsible for completion of the Abuse CQI tool, weekly for 4 weeks, bi-monthly for 2 months and quartley until compliance is maintained for 2 consecutive quarters. the results of these Audits will be reviewed by the CQI committee overseen by the ED. if threshold of 100% is not achieved an action plan will be devloped to assure compliance.Completion date 5/27/12	

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	hired. This attitude is not tolerated by management." The written narrative of the investigation from the Executive Director included, but was not limited to, the following information: On 3-2-12, at 12:00 P.M., ED/DNS [Executive Director/Director of Nursing Services] notified of the incident. On 3-2-12, at 3:00 P.M., MD [Medical Doctor] was notified of the incident. On 3-2-12, at 3:00 P.M., Family was notified of the incident. Written next to "ISDH notified date" was "N/A [Not applicable]." Written next to "APS notified date" was "N/A." Written next to "Ombudsmen notified date" was "N/A." A written statement by LPN #13 with no date or time noted indicated, "CNA [#14] walking out of dining room and said to one resident 'You keep asking me the same thing, I told you I'll do it when I get done, I'm busy.' CNA left dining room, came back and said to a resident, 'I wish I			

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	could just leave you in here.' I then called CNA to hallway, explaining to her this was an inappropriate way to speak to a resident. She said, 'OK, thanks' and walked away." A written statement by LPN #3 with no date or time noted indicated, "On 3-2-12, during lunch. CNA walked into assist dining room and told a res [resident] 'she wished she could just leave her in here.' Charge nurse immediately spoke to CNA about her comment/behavior." A written statement by DNS dated 3-6-12 and titled "Summary of the Alleged Abuse Investigation" indicated "DNS and Social Service Director concluded the investigation. It was discovered that CNA was not being respectful to the resident. It is against our policy as ASC to condone any form of disrespectful act by any of our staff to our residents. Subsequently CNA was terminated by DNS on 3-6-12." On 4-24-12 at 12:00 P.M., Resident D's record was reviewed. Diagnoses included, but were not limited to, dementia. An MDS [Minimum Data Set] assessment screening dated 4-6-12, included, but was not limited to, "BIMS [Brief Interview Mental Status] screening score 8 [moderate cognitive impairment]			

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	... Behavioral Symptom - Presence and Frequency: Delirium present ...." A "Nurses Notes" dated 3-2-12, at 3:00 P.M., included, but was not limited to, "Call placed to [name of daughter] re [regarding] staff making inappropriate comments to resident; spoke with resident who had no concerns at this time. Follow up with psyco[sic]-social needs per social services. MD notified, no new orders." On 4-25-12, the DNS provided the facility's time sheet, dated 3-1-12 through 3-30-12. CNA #14 was present on 3-2-12 [date of alleged abuse allegation] from 6:42 A.M. to 3:08 P.M. In an interview on 4-27-12, at 1:10 P.M., the Executive Director indicated how he always handled investigations was to ask the resident first, then decide whether to report to State agencies. He indicated, otherwise, he'd be reporting every day. In an interview on 4-27-12, at 2:20 P.M., the Executive Director indicated this was not abuse; it was "staff attitude." The Director of Nursing indicated the employee was terminated. 3.1-28(a)			

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F0248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to provide trips to venues outside of the facility as part of the activity program, to 6 of 11 residents interviewed in a group setting. This deficiency had the potential to affect 53 residents physically capable of participating in an extended trip or outing, of 120 residents currently residing in the facility. [Residents #9, #88, #69, #1, #90, and #92] Findings include: In interviews during the group meeting on 4/25/12 at 2:00 P.M., Residents #9, #88, #69, #1, #90, and #92 indicated the facility had not provided any trips to places like restaurants, shopping stores/malls, or other entertainment venues of interest to them. Resident #88 indicated she had been in the facility for about 13 months, and had never been offered a trip of any kind. All of the residents indicated they really would like to go someplace outside of the facility,	F0248	1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice?We have a transportation director who will coordinate with the activity Director to ensure a schedule is implemented for resident outings. Resident #1,90, and 92 have participated in our outings on May 4th an May 10th. Resident #88 refused to go, and resident These outings will occur on a monthly basis.2.How other residents having the potential to be affected by same deficient practice will be identified and what corrective actions will be taken?All residents have the potential to be affected. a schedule has been implemented for outside outings on a monthly basis. This schedule will be communicated to all residents during resident council meeting to be held on May 29, 2012. Activity director will also communicate with residents during his one on one visits.This will also be put on the calender on a monthly basis.3.what measures will be put in place or what systematic changes will be made to ensure	05/27/2012

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	and when each had asked about going somewhere, they were told "We're considering that," or "We're working on it." They were also told that the facility transport van was not running or needed some kind of repair. The Activity program calendars for January, February, March, and April, 2012 were reviewed. There was no entry listing a trip to any venue outside of the facility in any of the 4 months. In an interview on 4/16/12 at 9:50 A.M., the Activity Director indicated he had been in that position only since about mid-February, 2012. He had previously worked in the facility as an Activity assistant. He indicated that during his Activity Director training he became aware activities were required to be provided outside of the facility, and had started to plan some trips. He indicated the facility van had needed some parts for repairs, but that was now completed. An alternate source of transportation had not been explored. The Activity Director indicated that, as far as he was aware, the previous Activity Director had never scheduled or arranged any trips--he did not know why. 3.1-33(b)(3)		the deficient practice does not recur?The ED/ or designee will monitor the schedule outing program monthly to ensure residents are given a choice on wheather to participate in outings or not.4 How the correction action will be monitored to ensure deficient practice will not recur? The participation record and field trip booklet will be updated to show residents who have participated in outings. The activity outing booklet will be reviewed monthly for 4 months to ensure outside activities are taken place. the results of these audits will be reviewed by the CQI committee overseen by the ED. it threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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F0253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to maintain proper storage and cleanliness of 1 of 2 wheelchair scales observed in the hallway of the 100 unit. This deficient practice impacted 1 of 5 units and had the potential to affect 7 of 20 residents residing on the 100 unit who were identified as mobile with confusion. Findings include: On 4/23/12 at 10:30 A.M., tour of the 100 hall was initiated with Licensed Practical Nurse #1. During tour, 7 of 20 residents were identified as confused and ambulatory or mobile in a wheelchair without assistance. On 4/24/12 at 10:00 A.M., environmental tour was initiated with the Maintenance Supervisor. On 4/24/12 at 10:10 A.M., a wheelchair scale was observed in the hallway of unit 100. The wheelchair scale had scattered debris that appeared to be food crumbs as well as dark brown, dirt-like matter on	F0253	1. what corrective action will be accomplished for those residents found to have been affected by the deficient practice?the wheel chair scale has been cleaned and put on a daily cleaning assignment to ensure cleanliness.2.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?All residents have the potential to be affected. we will review the wheel chair scale cleaning schedule 3 times a week during morning meeting to ensure compliance. The wheel chair scale is placed on a daily cleaning schedule by the housekeeping department. 3. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? On 5/8/12 the SDC inserviced staff on wheel chair scale cleanliness and the new wheelchair scale cleaning schedule. The housekeeping Supervisoer will ensure the scales are clean.4.how the corrective actions will be monitored to ensure the deficient practice will not recur?the wheel chair scale cleaning schedule will be reviewed 3 times a week for	05/27/2012

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	both sides of the scale. At that time, in an interview, the Maintenance Supervisor indicated the wheelchair scale needed cleaned. 3.1-19(f)		the first month and then weekly for the second month and then monthly thereafter for at leasr six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance	

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, record review, and interview, the facility failed to implement appropriate fall interventions to prevent injury of a resident who was identified as high fall risk on admission. This deficient practice affected 1 of 13 residents reviewed for falls in a sample of 24 residents reviewed. [Resident N] B. Based on observation, record review, and interview, the facility failed to properly store chemicals out of reach of residents. This deficient practice impacted 3 of 5 units and had the potential to affect 49 of 120 residents residing in the facility who were identified with a history of confusion and were ambulatory or mobile in a wheelchair without assistance. C. Based on observation, record review, and interview, the facility failed to secure sharp objects on 1 of 1 dementia unit. This deficient practice had the potential to affect 36 residents residing on the locked dementia unit who were identified as ambulatory or mobile in a wheelchair	F0323	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A new fall risk assesment was completed on resident N on 5/9/12. along with care plan review with current interventions. An inservice was held with all staff members on 5/8/12 regarding proper storage of chemicals(hand sanitizer, and deoderizer) and sharp objects being secured from our resident population. 2.How other residents having the potential to be affected by the same deficient practice will be identified All residents have the potential to be affected. A new fall risk assesment was completed for all residents. IDT will review falls and interventions Monday-Friday to ensure that interventions are appropriate and adequate.An inservice was held on 5/8/2012 that included fall prevention, all chemicals and sharp object store out of reach of resident. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? On 5/8/2012, SDC in-serviced all staffon fall prevention,	05/27/2012

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	without assistance of 120 residents residing in the facility. Findings include: A1. On 4/24/12 at 1:20 P.M., Resident N's record was reviewed. Diagnoses included, but were not limited to, falls, chronic obstructive pulmonary disease, Alzheimer's disease, cancer of the bladder, venous thrombosis, and pneumonia. Resident N was admitted to the facility on 3/1/12. An admission "Fall Risk Assessment," no date, included, but was not limited to, "New Admission: yes... History of falls: yes... Resident receives medications in the following categories: Antihypertensives and Narcotics... Resident has diagnosis of and/or demonstrates evidence of impaired gait/balance: yes... Assistive devices: wheelchair and rolling walker... Resident is non-compliant or has history of non-compliance: yes..." An admission "Minimum Data Set" screening dated 3/8/12, included, but was not limited to, "Brief Interview Mental Status [BIMS: 12 [moderately impaired]...Section G: Functional Status: Bed mobility, transfer, toilet use, and personal hygiene... extensive assistance with 2 or more staff... Locomotion on/off		appropriate and adequate intervention to reduce falls or injury, all chemicals and sharp objects to be locked out of reach of our residents. Residents will be reviewed by IDT team upon admission, significant changes, and on a quarterly and annual review in order to ensure appropriate interventions are in place and are effective. 4, How the corrective actions will be monitored to ensure the deficient practice will not recur? IDT will review all falls and interventions to ensure intervention are adequate and appropriate, DNS is responsible to ensure fall risk management CQI tool is utilize on new falls daily for one month, weekly for the second month, then twice a month for the last month. ED/Designee will be responsible for utilizing a CQI resident rounding tool to monitor and ensure that chemicals and sharp object are out of reach of residents. This tool will be utilized three times a week for the first month, weekly for the second month, and twice a month for the third month.The result of this audit will be review by CQI committee overseen by the ED. If the threshold of 100% is not archieve, and action plan will be developed to assure compliance.	

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	unit... total dependence with 1 staff person..." An "Occupational Therapy Progress Report" dated 3/9/12 through 3/15/12, included, but was not limited to, "Patient's progress as follows: Transfer: General: The patient is able to safely perform wheelchair to recliner transfers requiring CG [contact guard assist: contact with patient due to unsteadiness]... Reason for continuation of care: Remaining impairments in pain, strength, endurance, and balance impacting ADL [activities of daily living] safety and participation..." A "Physical Therapy Progress Report" dated 3/10/12 through 3/16/12, included, but was not limited to, "Long Term Goal: Supervision with all functional transfers... Precautions: High fall risk due to generalized weakness and balance deficit, history of multiple lower extremity deep vein thrombosis, and Coumadin [blood thinner] therapy..." A "Nursing Progress Notes" dated 3/11/12 at 5:00 P.M., included, but was not limited to, "Resident is on fall follow up due to he fell trying to get to his wheelchair... found on floor by aide... will continue to monitor..." Documentation was lacking to indicate new interventions were placed to prevent further falls.			

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	A "Interdisciplinary Team [IDT] Progress Notes: dated 3/12/12 at 9:52 A.M., included, but was not limited to, "Fall: IDT met for fall review... on 3/11/12 at 3:35 P.M., resident [Resident N] told nurse he was attempting to transfer from his recliner to his wheelchair and fell... found sitting on his bottom [buttocks]... Resident was placed on hourly rounding..." A "Hourly Rounding" dated 3/12/12, included, but was not limited to, "Date: 3/12/12 at 10:00 A.M.... hourly rounding initiated..." A "Fall Care Plan" dated 3/12/12, included, but was not limited to, "Problem start date: 3/12/12... Resident [N] is at risk for fall due to: decline in mobility, cognition issues, needs assistance with all ADL needs... Approach Start Date: 3/12/12: Call light in reach, environmental changes, keep personal items within reach and clean/clutter free, non skid footwear, gripper socks when no shoes are worn, personal items in reach, place on hourly rounding, and therapy screen..." There was no "Nursing Progress Notes" dated 3/15/12 regarding the following fall.			

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	A "IDT Progress Notes" dated 3/16/12 at 9:49 A.M., included, but was not limited to, "IDT met to review fall that occurred on 3/15/12 at 10:29 P.M.... Resident had an unwitnessed fall in his room... found laying on his back beside the bed... Resident noted to be confused... gripper socks on... Immediate intervention: 15 minute checks for 24 hours... Pain medication recently increased with increased confusion noted after change... M.D. notified to review resident's medications... 72 hour follow up and neuro checks initiated... Resident currently in physical, occupational, and speech therapies for strengthening..." The "Approaches" dated 3/16/12 added to the 3/12/12"Fall Care Plan" included, 15 minute checks for 24 hours and medication review..." An "M.D. Visit" dated 3/16/12, no time, included, but was not limited to, "AMS [Acute Mental Status]/Lethargy due to medications... discontinue Neurontin and decrease Norco to PRN [as needed] only..." A "Nursing Progress Notes" dated 3/17/12 at 3:40 P.M., included, but was not limited to, "Resident had an unwitnessed fall... found in his room in			

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	the wheelchair tilted over on his left side to the floor... complained of left side pain, resident was confused... M.D. and family notified..." Documentation was lacking to indicate new interventions were placed to prevent further falls. A "Nursing Progress Notes" dated 3/19/12 at 8:05 A.M., included, but was not limited to, "Resident is confused ambulated self to recliner and dressed self when asked how he got into his recliner resident stated he did not remember..." Documentation was lacking to indicate new interventions were placed to prevent further falls. An "IDT Progress Notes" dated 3/19/12 at 11:12 A.M., included, but was not limited to, "IDT met for fall review: On 3/17/12 at 3:40 P.M., resident had an unwitnessed fall... he was found in his room, wheelchair on the floor, tipped over... We will remove wheelchair from room when resident is in room or recliner so resident will not be persuaded to transfer without assistance..." The "Approach" dated 3/19/12 added to the 3/12/12 "Fall Care Plan" included, will remove wheelchair from room so he will not try to transfer self..." A "Nursing Progress Notes" dated			

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	3/31/12 at 11:15 A.M., included, but was not limited to, "Resident noted to transfer self from bed to recliner [unassisted]... Educated resident to utilize call light for assistance..." Documentation was lacking to indicate new interventions were placed to prevent further falls. A "Nursing Progress Notes" dated 4/1/12 at 8:30 A.M., included, but was not limited to, "Patient [Resident N] was found sitting on floor at about 11:45 P.M. in his room... patient did indicate pain in his left hip... after a brief passive range of motion on both upper and lower extremities , patient assisted back to bed... M.D. notified... patient's son notified..." A "Nursing Progress Notes" dated 4/1/12 at 11:30 A.M., included, but was not limited to, "Resident found to be in extreme pain... M.D. and family notified... to emergency room to rule out left hip fracture..." An "IDT Progress Notes" dated 4/2/12 at 8:53 A.M., included, but was not limited to, "IDT met for fall review: On 3/31/12 at 11:45 P.M., resident found on floor in his room... he was in bed prior to fall... 15 minute checks were initiated..." Documentation was lacking to indicate new interventions were placed to prevent further falls.			

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	On 4/27/12 at 10:00 A.M., all information regarding fall interventions for Resident N were requested from the DoN. On 4/27/12 at 1:00 P.M., the charting for Resident N's hourly rounding was received. No further documentation was received regarding fall interventions for Resident N. A summary from the "Nursing Progress Notes" regarding Resident N's falls and interventions placed by the facility is as follows: 3/11/12 at 3:35 P.M., resident [Resident N] told nurse he was attempting to transfer from his recliner to his wheelchair and fell... No immediate intervention. On 3/12/12 at 10:00 A.M., hourly rounding initiated. 3/15/12 at 10:29 P.M.... Resident had an unwitnessed fall in his room... found laying on his back beside the bed... gripper socks on... Immediate intervention: 15 minute checks for 24 hours... Pain medication reviewed and decreased on 3/16/12, no time. 3/17/12 at 3:40 P.M., Resident had an unwitnessed fall... found in his room in the wheelchair tilted over on his left side			

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	to the floor... On 3/19/12, no time, wheelchair removed from room. 3/31/12 at 11:45 P.M., found sitting on floor in his room... Intervention: Assisted back to bed, pain medication... 4/1/12 sent to emergency room with fractured left hip. The "Nursing Progress Notes" indicated Resident N was hospitalized on 4/1/12 for a left hip fracture and returned to the facility on 4/6/12 at 7:24 P.M. After injury, the following interventions were added to his care plan, "Fall Care Plan" dated 3/12/12, included "Approach" dated 4/9/12, "bed and wheelchair alarms..." A2. On 4/23/12 at 2:30 P.M., the facility fall management policy and procedure was requested from the Executive Director. On 4/24/12 at 9:00 A.M., the Executive Director provided, "Fall Management Program" dated 3/10. The "Fall Management Program" included, but was not limited to, "Policy: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through			

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	the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls..." B1. On 4/23/12 at 10:30 A.M., tour was initiated on the 100 unit with LPN #1. At that time, LPN #1 indicated 7 of 20 residents residing on the 100 unit had a history of confusion and ambulated or used a wheelchair without assistance. On 4/23/12 at 10:45 A.M., tour of the locked Memory Care Unit was initiated with LPN #10 . At that time, LPN #10 indicated 36 of 36 residents residing on the locked Memory Care Unit had confusion and were ambulatory or used a wheelchair without assistance. On 4/23/12 at 11:00 A.M., tour of the 400 unit was initiated with LPN #2. At that time, LPN #2 indicated 6 of 14 residents residing on the 400 unit had a history of confusion and were ambulatory or used a wheelchair without assistance. On 4/24/12 at 10:00 A.M., environmental tour was initiated with the Maintenance Supervisor. On 4/24/12 at 10:10 A.M., an aerosol can of Puricit Odor Eliminator was observed on a linen cart located on the 100 unit.			

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In an interview at that time, the Maintenance Supervisor indicated he was aware all chemicals should not be left unattended in resident areas. The Maintenance Supervisor removed the chemical from the linen cart.

On 4/24/12 at 10:20 A.M., on the locked Memory Care Unit, 2 open 4 ounce bottles of Medi-Pak Performance Instant Hand Sanitizer were observed in an unlocked drawer in a portable baking cart located in the activity area of the unit.

At that time, the Maintenance Supervisor indicated all drawers are to be locked in the Memory Care Unit at all times. Staff were made aware by the Maintenance Supervisor and all drawers were then secured.

On 4/24/12 at 10:30 A.M., on the 400 Unit, 1 open 4 ounce bottle of Medi-Pak Performance Instant Hand Sanitizer was observed on the medication cart in the hallway of the unit.

At that time, in an interview, the Maintenance Supervisor indicated he would remind staff to keep the hand sanitizer locked in the medication cart.

C1. On 4/24/12 at 10:20 A.M., on the

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	locked Memory Care Unit, the drawers in the kitchenette area were unlocked. 2 metal cookie cutters with sharp edges were observed in the one unlocked drawer. At that time, the Maintenance Supervisor indicated all drawers and cabinets were to be locked in the Memory Care Unit. He instructed staff to lock the drawers/cabinets. On 4/24/12 at 11:00 A.M.., the Material Safety Data Sheets were requested for the hand sanitizer and odor eliminator from the Maintenance Supervisor and the facility policy on chemical storage. On 4/24/12 at 2:00 P.M., the Material Safety Data Sheets for the hand sanitizer and odor eliminator and a document titled "Safety" no date, were received from the Executive Director. The "Medi-Pak Performance Instant Hand Sanitizer" Material Safety Data Sheet included, but was not limited to, "Hazardous Components: Denatured Ethyl Alcohol... Possible Routes of Entry into the Body: Eyes, Ingestion, Inhalation... Signs and Symptoms of Exposure: Possible watering, burning and redness... Swallowed: Possible gastrointestinal irritation or disturbance...			

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	Inhalation: Possible giddiness or loss of consciousness..." The bottle was marked, "Keep Out of Reach of Children." The "Ready To Use Odor Eliminator" Material Safety Data Sheet included, but was not limited to, "Hazards Identification: Caution: May be mildly irritating to eyes and skin, may cause abdominal discomfort, nausea, vomiting, and diarrhea..." The aerosol can was marked, "Keep Out of Reach of Children." A document titled, "Safety" no date, included, but was not limited to, "All cleaning supplies must be kept in locked storage rooms... Cleaning supplies in remote locations, i.e., activity room, general public areas, nursing stations... should be in locked storage when not in use..." This federal tag relates to Complaint IN00107010. 3.1-45(a)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation , interview, and record review, the facility failed to ensure hair was secured in hair nets in the kitchen, and food being served was properly stored, covered and protected from possible contamination. The lack of use of hair nets had the potential to affect 120 residents who eat food served from 1 of 1 kitchen of 120 residents in the facility. The improperly covered food had the potential to affect 56 residents who eat food served in the 500 hall dining room. The improperly stored food had the potential to affect 36 residents who reside in the Cottage unit. Findings include: During an observation in the kitchen on 4/23/12 at 10:10 A.M. during tour, Cook #12 was noted to have several hairs sticking out of the bottom of her hair net while preparing food. During an observation in the kitchen on 4/24/12 at 10:30 A.M. Cook #12 was	F0371	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?An inservice was held on 5/1/12 for all dietary employees on properly securing all of the hair in a hairnet, and proper covering of food served to our residents.2.How other residents having the potential to be affected by the same deficient practice will be identified and what correction action will be taken?all residents have the potential to be affected. an inservice was held on 5/1/12 with all dietary employees ensuring that all of the haie is secured in the hairnet as well as the proper covering of food items and ensuring utensils are not left in storage bins.3. What measures were put in place or systemic changes will be made to ensure that a deficient practice doe not recur?daily rounding by the dietary manager to ensure dietary staff properly secure there hair and coverage of food being served. she will also monitor storage bins to ensure utensils are not left in the bins.4.How the corrective action will be monitored	05/27/2012

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	noted in the kitchen working with food and her hair was not secure in the hair net. During an observation on 4/25/12 at 11:20 A.M. Cook #9 was cooking the food and checking temperatures of the food and was noted to have one large strand of hair hanging out of her hair net. Dietary Aid #8 also had several strands of hair sticking out of the back of her hair net. During environmental tour on 4/24/12 at 10:20 A.M. the Cottage kitchen was noted to have a covered metal container of brown sugar on top of the refrigerator. Inside of the metal container was a spoon. During the lunch hour in the 500 hall dining room on 4/24/12 at 12:30 P.M. There were two, three tier carts with desserts on them. The cart in the middle dining room was wheeled around from resident to resident to choose which dessert they want. One cart had 5 bowls of red applesauce on the bottom tier, 8 bowls on the middle tier, and 2 bowls of cupcakes on the top tier. The cart in the side dining room had 3 bowls of applesauce and one cupcake on the top tier, the middle tier had 3 bowls of red applesauce and the bottom tier had 1 cupcake and 1 blueberry cobbler on it. All of these desserts observed had nothing		to ensure the deficient practice will not recur?To ensure compliance the dietary manager will monitor staff daily for securing all hair under hairnet, proper coverage of food being served, and utensils left in storage bins. this will be monitored daily for 4 weeks, and then weekly for one month and then 2 times a month thereafter, The dietician will review this on a weekly basis to ensure compliance. the results of these audits will be reviewed by the CQI committee overseen by the ED. if the threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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	covering them. In an interview with the Dietary Manager on 4/25/12 at 11:23 A.M. she indicated the kitchen staff should have all of their hair inside their hair net. She further indicated she does not usually cover the desserts as they want a fine dining atmosphere for their residents. In an interview with the Executive Director on 4/25/12 during the exit conference at 3:20 P.M. he indicated they never cover their desserts. He also indicated they have no policy in regard to the covering of the food. In an interview with the Maintenance Director on 4/24/12 at 10:23 A.M. he indicated the spoon should not be kept inside the container of brown sugar on the Cottage Unit. In a policy provided by the Executive Director on 4/26/12 at 9:15 A.M. titled "Infection Control" dated 2/02 with revision dates of 3/04, 5/06, and 4/11, the policy indicated, "...c) All staff will wear hair restraints that will cover all hair..." There was nothing pertaining to the covering of food. "Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the			

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	following: SEC 179(a) " food on display shall be protected from contamination by the use of: (1) packaging; (2) counter, service line, or salad bar food guards; (3) display cases; or (4) other effective means..." 3.1-21(i)(3)			

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to accurately label 1 of 3 open multiple dose tubersol vials with an open date. This	F0431	1. what corrective action will be accomplished for those residents found to have been affected by deficient practice?On 5/8 2012 the SDC inserviced all nursing	05/27/2012

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	deficient practice had the potential to impact 16 of 16 new residents admitted to the facility in April, 2012 who required tuberculin skin testing. The facility failed to accurately label 2 of 2 open multiple dose dietary supplement bottles [Resident #123] with an open date, and 1 of 2 open multiple dose dietary supplement bottles with a resident identifier. This deficient practice was observed in 1 of 1 medication refrigerator. Findings include: 1. On 4/23/12 at 11:00 A.M., the Executive Director provided a copy of the "April 2012 Admissions" ad requested upon entrance to the facility. At that time, the "April 2012 Admissions" were reviewed. The facility had 16 new residents admitted in the month of April. These residents required tuberculin skin testing. On 4/26/12 at 11:00 A.M., tour of the medication room was initiated with Licensed Practical Nurse [LPN] #7. On 4/26/12 at 11:05 A.M., 1 of 3 open vials of tubersol [Tuberculin Purified Protein Derivative] was observed without an open date. At that time, in an interview, LPN #7		staff on tubersol viles and the dietary supplement feeding for resident 123. All tubersole viles and dietary supplements are labeled with open dates.2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action will be taken.All residents have the potential to be affected.On 5/8 2012 the SDC inserviced all nursing staff on tubersol viles and the dietary supplement feeding . All tubersole viles and dietary supplements are labeled with open dates.3. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?SDC will continue to inservice nursing staff on making sure tubersole and dietary supplements are dated and labeled with open date.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?To ensure compliance a medication storage review CQI tool will be utilized by all nursing staff to be performed each shift and given tothe DON dailey for 30 days and bi-monthly for one month and then monthly therafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.	

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	indicated the open date should be written on each open bottle of medication. LPN #7 disposed of the vial of tubersol. 2. On 4/26/12 at 11:10 A.M., a 32 fluid ounce dietary supplement bottle [Cherry Berry Aloe Vera] was observed 1/2 empty without an open date for Resident #123 and a 33.8 fluid ounce dietary supplement bottle [Pure Aloe Force] was observed 1/4 empty without an open date or resident identifier. At that time, in an interview, LPN #7 indicated she was not aware who the Pure Aloe Force was prescribed to and knew all medications must be accurately labeled. 3.1-25(j) 3.1-25(k) 3.1-25(l)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to ensure the ice scoop was	F0441	1. what corrective action will be accomplished for those residents	05/27/2012

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	not stored inside of 1 ice chest, on 1 of 5 units. The deficient practice had the potential to affect 14 residents who resided on the 400 unit of 120 residents currently residing in the facility and who were provided ice. Findings include: On 4/24/12 at 10:00 A.M., environmental tour was initiated with the Maintenance Supervisor. On 4/24/12 at 10:30 A.M., a portable ice chest cart was observed in the hallway on the 400 unit. The scoop used to obtain the ice from the chest was inside the container, and positioned on top of the ice. In an interview at that time, the Maintenance Supervisor indicated nursing staff were not allowed to store the scoop in the ice chest. The scoop was removed from the ice chest, and both the scoop and ice chest were then removed from the unit by Licensed Practical Nurse #2 for cleaning. 3.1-18(b)(1)		found to have been affected by the deficient practice? SDC inserviced all staff on 5/8/12 on properly storing of the ice scoop when not in use. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what correction actions will be taken? All residents have the potential to be affected. SDC inserviced all staff on properly storing of the ice scoop when not in use. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does nopt recur? continued inservices regarding infection control not just limited to ice scoops will be held on a monthly basis to ensure compliance. 4. How the corrective action will be monitored to ensure the deficient practice will not recur? A resident round CQI tool which includes monitoring of the ice chest and proper placement of the ice scoop will be utilized by the management team 3 times a week for the first month and twice a week for the second month and then weekly thereafter. the results of these audits will be reviewed by the CQI committee overseen by the ED. if the threshold of 100% is not achieved an action plan will be devloped to assure compliance.	

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F9999	State Finding: 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD)... The tuberculin skin test must be read prior to the employee starting work... (1) For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step... This state rule was not met as evidenced by: Based on record review and interview, the facility failed to provide employees with the two-step tuberculin skin test method in the time required by Indiana State Department of Health. The second tuberculin skin test was not completed within 1 to 3 weeks after the first	F9999	1. How corrective actions will be accomplished for those residents found to have been affected by deficient practice? Staff members 4,5,6 were restarted on the PPD's. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrections actions will be taken? SDC inserviced all staff that TB testing must be completed in a timely manner. the first step will be done before hire, and the second step willl be done two weeks following first step. a schedule has been created by SDC, and for those who do not show up for second step will be removed from payroll. 3. what measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? SDC will monitor schedule of all new hires to ensure 2nd step is being administered timely. 4. How the correction actions will be monitored to ensure the deficient practice will not recur. SDC Employy mantoux scheduled will be monitored by the DON on a weekly basis to ensure compliance. The results of the audit will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be devloped to assure compliance.	05/27/2012

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	tuberculin skin test. This deficient practice affected 3 of 15 employee files reviewed.[Occupational Therapist #6, Registered Nurse # 5, and Certified Nursing Assistant #4] Findings include: On 4/26/12 at 2:00 P.M., facility employee records were reviewed. At that time, the employee records of Occupational Therapist [OT] #6, Registered Nurse [RN] #5, and Certified Nursing Assistant [CNA] #4 were reviewed. OT #6's "Tuberculin Testing For Employees" dated 2/6/12, included, but was not limited to, "Hire date: 2/8/12... Date/Time Given [step one]: 2/6/12... Date Read: 2/8/12... Result: 0 millimeters... Retest of Mantoux (Step 2): no documentation noted...." OT #6's "Tuberculin Testing For Employees" dated 3/12/12, included, but was not limited to, "Hire date: 2/8/12... Date/Time Given [step one]: 3/12/12... Date Read: 3/15/12... Result: 0 millimeters... Retest of Mantoux (Step 2): Date/Time Given [step 2]: 3/28/12... Date Read: 3/30/12... Result: 0 millimeters..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	04/27/2012

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	RN #5's "Tuberculin Testing For Employees" dated 11/21/11, included but was not limited to, "Hire date: 11/21/11 ... Date/Time Given [step one]: 11/21/11... Date Read: 11/23/11... Result: 0 millimeters... Retest of Mantoux (Step 2): no documentation noted...." RN #5's "Tuberculin Testing For Employees" dated 1/10/12, included, but was not limited to, " "Hire date: 11/21/11 ... Date/Time Given [step one]: 1/10/12... Date Read: 1/12/12... Result: 0 millimeters... Retest of Mantoux (Step 2): Date/Time Given: 1/27/12... Date Read: 1/30/12... Result: 0 millimeters..." CNA #4's "Tuberculin Testing For Employees" dated 2/8/12, included, but was not limited to, "Hire date: 1/11/12... Date/Time Given [step one]: 2/8/12... Date Read: 2/10/12... Result: 0 millimeters... Retest of Mantoux (Step 2): Date/Time Given: 2/13/12... Date Read: 2/15/12... Result: 0 millimeters..." On 4/26/12 at 3:30 P.M., during daily exit conference, other tuberculin skin testing was requested from the Executive Director regarding the above employees. On 4/27/12 at 9:30 A.M. in an interview, the Executive Director indicated he did			

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	155786	A. BUILDING 00 B. WING	04/27/2012

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	not have any further documentation to provide for the above employees. 3.1-14(t)(1)			